Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

October 24, 2017

Ms. Angela Pelletier, Manager
Spring Village At Essex
6 Freeman Woods
Essex, VT 05451

Dear Ms. Pelletier:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on September 21, 2017. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0653	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VILLAGE AT ESSEX	6 FREEMAN WOODS ESSEX, VT 05451

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: An unannounced investigation of two complaints was conducted by the Division of Licensing & Protection on 9/19-21/2017. The following regulatory deficiencies were identified as a result of the investigation:	R100	Please see attached plans of correction.	
R126 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.5 General Care 5.5.a Upon a resident's admission to a residential care home, necessary services shall be provided or arranged to meet the resident's personal, psychosocial, nursing and medical care needs. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to assure that necessary services are provided or arranged to meet the resident's personal, psychosocial, nursing and medical care needs. Findings include: 1. Per staff interview with the Director of Nursing Services, during the night shift on 9/20-21/17 at approximately Midnight, staff called him/her at home due to a resident with escalating aggressive behaviors. During the incident Resident #1 was noted by a caregiver coming out of his/her room. As s/he proceeded toward the staff member she was "screaming" and started taking pictures off the wall. EMT (Emergency Medical Technician) and the Police were called to the scene as staff could not contain the situation. During the incident it is suspected (though not	R126		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: A. Pelletier — TITLE: Acting Executive Director / Director of Operations — (X6) DATE: 10/13/17

R126 - R179 POCs accepted 10/24/17 mtiggino RN/PMC

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R126	Continued From page 1	R126		

witnessed) that R#1 pulled one resident (R#2) out of bed while staff were doing rounds. It is also noted that s/he also entered the room of R#3, while staff were speaking with responders, and sat on the bed (also sitting on the resident). During the visit it is reported that staff stated to Emergency Responders that the staff felt unprepared to deal with the situation and unsupported by management. Emergency Responders note that it is not the first time they have been called to the facility to assist with resident behaviors. It was also noted that during the incident staff were engaged in trying to contain R#1 and protect other residents which precluded them having the ability to check other residents, do 15 minute safety checks, and perform other job duties.

Per interviews on 9/22/17, the staff present during the incident above confirmed that staffing numbers precluded them from doing every 15 minute checks and other duties when a resident became agitated or needed additional monitoring. They stated that this does happen on the night shift on occasion and that it then takes away from other care provision.

Additionally, per record review and interview, the facility should have been aware for the need for increased supervision for this resident, as R#1 had escalating behaviors on 9/17/17 and at that time s/he struck R#4 on the back while walking behind him/her. The incident seemed to have happened without provocation.

2. On 9/19/17 during a dinner observation in the Junction dining room, Residents were moved into the room starting at 4:35 PM. At 5 PM, residents were still being moved into the dining room and a staff member began serving water. The staff

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R126	Continued From page 2 member then left to go into the kitchen to begin carrying dinner plates into the dining room and serving residents. During this time, the dining room was unattended by staff on 3 occasions while food was in place. During this time, one resident got up and walked away from the table. A staff member went to find that resident and guide him/her back into the room. Several minutes later, a resident needed to use the bathroom and a staff member assisted him/her to the bathroom and returned several minutes later. During this time the second staff member was serving dinner, leaving the room frequently to obtain dinner plates. Two family members were in the dining room with their spouses and one family member got up and assisted several residents to cut their salad into more manageable pieces. 3. During the survey visit 9 anonymous staff members were interviewed and of these, 7 staff stated when asked, that the current staffing prevents them from doing every 15 minute checks and other aspects of their job. They also stated that they have been asked to work extra shifts or stay late because of inadequate staffing. Of note, staff are reluctant to answer questions during the survey process because they are fearful of retaliation. 4. In a review of other documents, local Police have responded to multiple calls from facility staff, especially on the evening and night shifts, for assistance with resident behaviors and with residents exiting the facility. In one instance a resident was found several miles away at a busy intersection.	R126		
R132 SS=E	V. RESIDENT CARE AND HOME SERVICES	R132		

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R132	Continued From page 3 5.5 Special Care Units 5.6.c A home that has received approval to operate a special care unit must comply with the specifications contained in the request for approval. The home will be surveyed to determine if the special care unit is providing the services, staffing, training and physical environment that was outlined in the request for approval. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to assure that the Special Care Unit (SCU) is providing the services, staffing, and training that was outlined in the request for approval. This entire building is categorized as a SCU. Findings include: In the request for approval to operate the SCU, the facility stated that the services would provide for the care of residents with Dementia in the least restrictive environment while keeping the residents safe. In a review of facility incidents, Resident #1 was walking behind Resident #4 on 9/17/17 and struck that resident on the back, which should have alerted the facility that additional supervision is necessary to protect other residents. On 9/20/17 it is suspected that Resident #1 pulled Resident #2 from bed to the floor and it is confirmed that R#1 entered the room of R#3 that same night, who was lying in bed, and sat on him/her. Resident #3 is on every 15 minute safety checks and during both the last survey, completed 8/30/17 and this investigation, the checks are not being consistently conducted. In staff interviews 7 of 9 staff interviewed stated	R132		

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R132	Continued From page 4 that because of being "short staffed" they are unable to conduct the safety checks and cannot complete all their job duties. In a review of other documents, local Police have responded to calls from facility staff, especially on the evening and night shifts, for assistance with resident behaviors and with residents exiting the facility. In one instance a resident was found several miles away at a busy intersection The facility was cited for insufficient staffing during an investigation completed on 8/30/17 and despite this citation, the facility has continued to admit new residents and has lost several additional staff members. In an interview on 9/19/17, the Memory Care Manager stated that there is no information regarding the initial Dementia training given to all new staff, because his/her training book cannot be found. There are also no documents of completion of the training available. In interviews by Emergency Responders on the night of 9/20/17, they were informed that staff did not receive training about escalation of behaviors and approaches for residents with Dementia.	R132		
R141 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.9 Level of Care and Nursing Services 5.9.a Residents who require more than nursing overview or medication management shall not be retained in a residential care home unless the provisions of the following subsections (I)-(5) are all met:	R141		

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R141	Continued From page 5 (1) The nursing services required are either: i. Provided fewer than three times per week; or ii. Provided for up to seven days a week for no more than 60 days and the resident's condition is improving during that time and the nursing service provided is limited in nature; or iii. Provided by a Medicare-certified Hospice program; and (2) The home has a registered nurse on staff, or a written agreement with a registered nurse or home health agency, to provide the necessary nursing services and to delegate related appropriate nursing care to qualified staff; and (3) The home is able to meet the resident's needs without detracting from services to other residents; and (4) The home has a written policy, explained to prospective residents before or at the time of admission, which explains what nursing care the home provides or arranges for, how it is paid for and under what circumstances the resident will be required to move to another level of care; and (5) Residents receiving such care are fully informed of their options and agree to such care in the residential care home. This REQUIREMENT is not met as evidenced by: Based on observation, documentation, and staff interviews the facility failed to assure that the home is able to meet the resident's needs without detracting from services to other residents. Findings include: 1. Per staff interview with the Director of Nursing Services, during the night shift on 9/20-21/17 at	R141		

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R141	Continued From page 6	R141		

approximately Midnight, staff called him/her at home due to a resident with escalating aggressive behaviors. During the incident Resident #1 was noted by a caregiver coming out of his/her room. As s/he proceeded toward the staff member she was "screaming" and started taking pictures off the wall. EMT (Emergency Medical Technician) and the Police were called to the scene as staff could not contain the situation. During the incident it is suspected (though not witnessed) that R#1 pulled one resident (R#2) out of bed while staff were doing rounds. It is also noted that s/he also entered the room of R#3, while staff were speaking with responders, and sat on the bed (also sitting on the resident). During the visit it is reported that staff stated to Emergency Responders that the staff felt unprepared to deal with the situation and unsupported by management. Emergency Responders note that it is not the first time they have been called to the facility to assist with resident behaviors. It was also noted that during the incident staff were engaged in trying to contain R#1 and protect other residents which precluded them having the ability to check other residents, do 15 minute safety checks, and perform other job duties.

Per interviews on 9/22/17, the staff present during the incident above confirmed that staffing numbers precluded them from doing every 15 minute checks and other duties when a resident became agitated or needed additional monitoring. They stated that this does happen on the night shift on occasion and that it then takes away from other care provision.

Additionally, per record review and interview, the facility should have been aware for the need for increased supervision for this resident, as R#1

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R141	Continued From page 7	R141		

had escalating behaviors on 9/17/17 and at that time s/he struck R#4 on the back while walking behind him/her. The incident seemed to have happened without provocation.

2. On 9/19/17 during a dinner observation in the Junction dining room, Residents were moved into the room starting at 4:35 PM. At 5 PM, residents were still being moved into the dining room and a staff member began serving water. The staff member then left to go into the kitchen to begin carrying dinner plates into the dining room and serving residents. During this time, the dining room was unattended by staff on 3 occasions while food was in place. During this time, one resident got up and walked away from the table. A staff member went to find that resident and guide him/her back into the room. Several minutes later, a resident needed to use the bathroom and a staff member assisted him/her to the bathroom and returned several minutes later. During this time the second staff member was serving dinner, leaving the room frequently to obtain dinner plates. Two family members were in the dining room with their spouses and one family member got up and assisted several residents to cut their salad into more manageable pieces.

3. During the survey visit 9 anonymous staff members were interviewed and of these, 7 staff stated when asked, that the current staffing prevents them from doing every 15 minute checks and other aspects of their job. They also stated that they have been asked to work extra shifts or stay late because of inadequate staffing. The facility was cited for insufficient staffing during an investigation completed on 8/30/17 and despite this citation, the facility has continued to admit new residents and has lost several additional staff members. Of note, staff are

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R141	Continued From page 8 reluctant to answer questions during the survey process because they are fearful of retaliation. 4. In a review of other documents, local Police have responded to multiple calls from facility staff, especially on the evening and night shifts, for assistance with resident behaviors and with residents exiting the facility. In one instance a resident was found several miles away at a busy intersection.	R141		
R146 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.9.c (3) Provide instruction and supervision to all direct care personnel regarding each resident's health care needs and nutritional needs and delegate nursing tasks as appropriate; This REQUIREMENT is not met as evidenced by: Based on staff interviews the facility failed to assure that the Registered Nurse provides instruction and supervision to all direct care personnel regarding each resident's health care needs. Findings include: Per interview on 9/21/17, the facility Memory Care Manager, a Licensed Nursing Assistant (LNA) with additional Dementia training, is responsible for providing all training to the caregiver staff. S/he does all the orientation and Dementia training using videos and is also the supervisor for all caregiver staff. In an interview on 9/21/17, the RN/DNS (Registered Nurse/Director of Nursing Services) confirmed that s/he does not do the caregiver staff training and does not	R146		

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R146	Continued From page 9 supervise the direct care staff.	R146		
R150 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.9.c (7) Assure that symptoms or signs of illness or accident are recorded at the time of occurrence, along with action taken; This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to assure that that signs of an accident are recorded at the time of occurrence, along with action taken. Findings include: Per staff interviews, an incident occurred when a resident's behavior escalated into an aggressive incident, during which Emergency Responders were called. The incident took place in the early hours of 9/20/17 and included R#1 and two other residents (R#2 & R#3). When the surveyor requested the specifics of the incident, the morning of 9/21/17, the DNS was unable to provide all the facts of the incident. There was no documentation available other than one incident report containing very little information and the facility was requested to provide the incident reports from the care staff and Manager, who responded to the facility at the time, via e-mail. No additional documentation has been provided to the licensing agency as of 10/5/17.	R150		
R178 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services	R178		

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R178	Continued From page 10	R178		

5.11.a There shall be sufficient number of qualified personnel available at all times to provide necessary care, to maintain a safe and healthy environment, and to assure prompt, appropriate action in cases of injury, illness, fire or other emergencies.
This REQUIREMENT is not met as evidenced by:
Based on record reviews and staff interviews the facility failed to assure there was a sufficient number of qualified personnel available at all times to provide necessary care, to maintain a safe and healthy environment, and to assure prompt, appropriate action in cases of injury, illness, fire or other emergencies. Findings include:

1. Per staff interview with the Director of Nursing Services, during the night shift on 9/20-21/17 at approximately Midnight, staff called him/her at home due to a resident with escalating aggressive behaviors. During the incident Resident #1 was noted by a caregiver coming out of his/her room. As s/he proceeded toward the staff member she was "screaming" and started taking pictures off the wall. EMT (Emergency Medical Technician) and the Police were called to the scene as staff could not contain the situation. During the incident it is suspected (though not witnessed) that R#1 pulled one resident (R#2) out of bed while staff were doing rounds. It is also noted that s/he also entered the room of R#3, while staff were speaking with responders, and sat on the bed (also sitting on the resident). During the visit it is reported that staff stated to Emergency Responders that the staff felt unprepared to deal with the situation and unsupported by management. Emergency Responders note that it is not the first time they

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R178	Continued From page 11	R178		

have been called to the facility to assist with resident behaviors. It was also noted that during the incident staff were engaged in trying to contain R#1 and protect other residents which precluded them having the ability to check other residents, do 15 minute safety checks, and perform other job duties.

Per interviews on 9/22/17, the staff present during the incident above confirmed that staffing numbers precluded them from doing every 15 minute checks and other duties when a resident became agitated or needed additional monitoring. They stated that this does happen on the night shift on occasion and that it then takes away from other care provision.

Additionally, per record review and interview, the facility should have been aware for the need for increased supervision for this resident, as R#1 had escalating behaviors on 9/17/17 and at that time s/he struck R#4 on the back while walking behind him/her. The incident seemed to have happened without provocation.

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R178	Continued From page 12 and returned several minutes later. During this time the second staff member was serving dinner, leaving the room frequently to obtain dinner plates. Two family members were in the dining room with their spouses and one family member got up and assisted several residents to cut their salad into more manageable pieces. 3. During the survey visit 9 anonymous staff members were interviewed and of these, 7 staff stated when asked, that the current staffing prevents them from doing every 15 minute checks and other aspects of their job. They also stated that they have been asked to work extra shifts or stay late because of inadequate staffing. The facility was cited for insufficient staffing during an investigation completed on 8/30/17 and despite this citation, the facility has continued to admit new residents and has lost several additional staff members. Of note, staff are reluctant to answer questions during the survey process because they are fearful of retaliation. 4. In a review of other documents, local Police have responded to multiple calls from facility staff, especially on the evening and night shifts, for assistance with resident behaviors and with residents exiting the facility. In one instance a resident was found several miles away at a busy intersection.	R178		
R179 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.b The home must ensure that staff demonstrate competency in the skills and techniques they are expected to perform before	R179		

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R179	Continued From page 13 providing any direct care to residents. There shall be at least twelve (12) hours of training each year for each staff person providing direct care to residents. The training must include, but is not limited to, the following: (1) Resident rights; (2) Fire safety and emergency evacuation; (3) Resident emergency response procedures, such as the Heimlich maneuver, accidents, police or ambulance contact and first aid; (4) Policies and procedures regarding mandatory reports of abuse, neglect and exploitation; (5) Respectful and effective interaction with residents; (6) Infection control measures, including but not limited to, handwashing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions; and (7) General supervision and care of residents. This REQUIREMENT is not met as evidenced by: Based on documentation and staff interviews the facility failed to assure that that staff demonstrate competency in the skills and techniques they are expected to perform before providing any direct care to residents. Findings include: Per staff interview with the Director of Nursing Services, during the night shift on 9/20-21/17 at approximately Midnight, staff called him/her at home due to a resident with escalating aggressive behaviors. During the incident Resident #1 was noted by a caregiver coming out of his/her room. As s/he proceeded toward the staff member she was "screaming" and started taking pictures off the wall. EMT (Emergency	R179		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0653	A. BUILDING: _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VILLAGE AT ESSEX	6 FREEMAN WOODS ESSEX, VT 05451

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R179	Continued From page 14 Medical Technician) and the Police were called to the scene as staff could not contain the situation. During the incident it is suspected (though not witnessed) that R#1 pulled one resident (R#2) out of bed while staff were doing rounds. It is also noted that s/he also entered the room of R#3, while staff were speaking with responders, and sat on the bed (also sitting on the resident). During the visit it is reported that staff stated to Emergency Responders that the staff felt unprepared to deal with the situation and unsupported by management. Emergency Responders note that it is not the first time they have been called to the facility to assist with resident behaviors. An Emergency Responder stated that staff appeared to be "at a loss" how to respond to the escalating behaviors. Per interview on 9/21/17 the facility Memory Care Manager, a Licensed Nursing Assistant (LNA) with additional Dementia training, is responsible for providing all training to the caregiver staff. S/he does all the orientation and Dementia training using videos and is also the supervisor for all caregiver staff. This training is provided in a classroom setting and by observation of care provision by the Memory Care manager and other staff members. In an interview on 9/21/17 the RN/DNS confirmed that s/he does not do the caregiver staff training and does not supervise the direct care staff.	R179		

10/13/17

Ms. Pamela M. Cota, RN
Licensing Chief
Vermont Agency of Human Services
Department of Disabilities, Agency and Independent Living
Division of Licensing and Protection
HC2 South, 280 State Drive
Waterbury, VT 05671-2060

Dear Ms. Cota,

In response to the letter received dated October 9, 2017 regarding the complaint investigation that was completed by the Division of Licensing and Protection on September 21, 2017, I respectfully submit our Plan of Correction.

R126 SS=E

1) SVE has changed the policy for overnight staff. One caregiver will work with a resident that has any behavior concerns so the others can continue to do the safety checks or other job duties. The staff in question were trained in dementia however will be re-trained with an emphasis on behaviors on October 15 and/or 17, 2017. The supervisor will review All behavioral interventions with the care staff as they are added to the care plan. The supervisor will observe staff to ensure that behavioral interventions are implemented as addressed in the care plan. Any issues identified will be addressed with the individual involved for re-training. Retraining methods will include role play, return demonstration and discussion. Results of intervention observation will be reviewed at the Quality Assurance Meeting. Complete 10/15+17/2017

2) In speaking with Captain Rick Gary at the Essex Police Department he stated he had no concerns with our community. It is a community on Carmichael St. where they are "inodiated with calls and have to respond because they get no response when they call back."

3) The acting ED had a discussion with the DON regarding the importance of addressing resident behaviors immediately. The DON will address this with all nurses and med techs in a meeting on October 20, 2017. Since this incident the resident was hospitalized and medications were changed. The resident's care plan was updated since her return from the hospital. The ED will audit the charts weekly to insure the care plans and assessments are completed in a timely manner. Any issues identified will be

addressed with the staff person involved immediately. Audits will be reviewed weekly at the Quality Assurance meeting scheduled for Thursdays at 1:00pm. Complete 10/20/17

4) The Food Service Director and dietary team will ensure that all foods will be cut appropriately for residents coming straight from the kitchen.

5) There is a new procedure in place for the dining room. One staff member will remain in the dining room at all times while the others provide the food or attend to other needs of the residents. This was in-serviced on 9/27/17. Complete 9/27/17

R132 SS=E

1) SVE has changed the policy for overnight staff. One caregiver will work with a resident that has any behavior concerns so the others can continue to do the safety checks or other job duties. The staff in question were trained in dementia however will be re-trained with an emphasis on behaviors on October 15 and/or 17, 2017. The supervisor will review All behavioral interventions with the care staff as they are added to the care plan. The supervisor will observe staff to ensure that behavioral interventions are implemented as addressed in the care plan. Any issues identified will be addressed with the individual involved for re-training. Retraining methods will include role play, return demonstration and discussion. Results of intervention observation will be reviewed at the Quality Assurance Meeting. complete 10/15+17/2017

2) In speaking with Captain Rick Gary at the Essex Police Department he stated he had no concerns with our community. It is a community on Carmichael St. where they are "inodiated with calls and have to respond because they get no response when they call back."

3) The acting ED had a discussion with the DON regarding the importance of addressing resident behaviors immediately. The DON will address this with all nurses and med techs in a meeting on October 20, 2017. Since this incident the resident was hospitalized and medications were changed. The resident's care plan was updated since her return from the hospital. The ED will audit the charts weekly to insure the care plans and assessments are completed in a timely manner. Any issues identified will be addressed with the staff person involved immediately. Audits will be reviewed weekly at the Quality Assurance meeting scheduled for Thursdays at 1:00pm.
Complete 10/20/17

4) Two agencies were contracted to assist the community in their staffing needs as of September 25, 2017. Agency will stay in place until the community has hired all staff necessary to meet the needs of the residents of a special care unit. The supervisor will review staffing levels daily and adjust accordingly to ensure appropriate staffing to

accommodate the needs of the residents in the Community. Results of the daily review will be reported at the Quality Assurance Meeting.

5) Since the complaint investigation a document was found dated 8/28/17 that indicates who has had dementia training. The three staff members on the night of the incident with resident #1 were listed on this document. However, all three will attend a re-training on October 15 and/or 17, 2017 with an emphasis on behaviors. The supervisor will review all behavioral interventions with the care staff as they are added to the care plan. The supervisor will observe staff to ensure that behavioral interventions are implemented as addressed in the care plan. Any issues identified will be addressed with the individual involved for re-training. Retraining methods will include role play, return demonstration and discussion. Results of intervention observation will be reviewed at the Quality Assurance Meeting. Complete 10/15+17/2017

R141 SS=E

1) The community has a full time DON that is a licensed RN on staff as of September 2017. She is responsible for assessing and determining if the community can meet the needs of the resident prior to admission as well as once an established resident of the community.

2) The resident agreement provides information regarding the care the community provides as well as how a third-party vendor payment would be paid for. It also includes why a transfer based on care needs would be handled.

3) SVE has changed the policy for overnight staff. One caregiver will work with a resident that has any behavior concerns so the others can continue to do the safety checks or other job duties. The staff in question were trained in dementia however will be re-trained with an emphasis on behaviors on October 15 and/or 17, 2017. The supervisor will review All behavioral interventions with the care staff as they are added to the care plan. The supervisor will observe staff to ensure that behavioral interventions are implemented as addressed in the care plan. Any issues identified will be addressed with the individual involved for re-training. Retraining methods will include role play, return demonstration and discussion. Results of intervention observation will be reviewed at the Quality Assurance Meeting. complete 10/15+17/2017

4) In speaking with Captain Rick Gary at the Essex Police Department he stated he had no concerns with our community. It is a community on Carmichael St. where they are "inodiated with calls and have to respond because they get no response when they call back."

5) The acting ED had a discussion with the DON regarding the importance of addressing resident behaviors immediately. The DON will address this with all nurses and med techs in a meeting on October 20, 2017. Since this incident the resident was hospitalized and medications were changed. The resident's care plan was updated since her return from the hospital. The ED will audit the charts weekly to insure the care plans and assessments are completed in a timely manner. Any issues identified will be addressed with the staff person involved immediately. Audits will be reviewed weekly at the Quality Assurance meeting scheduled for Thursdays at 1:00pm. Complete 10/20/17

6) The Food Service Director and dietary team will ensure that all foods will be cut appropriately for residents coming straight from the kitchen.

7) There is a new procedure in place for the dining room. One staff member will remain in the dining room at all times while the others provide the food or attend to other needs of the residents. This was in-serviced on 9/27/17. Complete 9/27/17

R146 SS=E

1) The RN/DNS is responsible for the care plans of the residents. The Memory Care Director takes the information of the care plans and inputs it into an assignment sheet the care providers use to care for the residents on a daily basis. The RN/DNS is involved in all care aspects of the residents as well as clinical. If there are any concerns or issues they are discussed with the RN/DNS for direction or updates in the care plans. The Memory Care Director trains all staff in dementia using her previous training, videos and several documents specific to dementia.

R150 SS=E

1) The information requested was faxed on 9/22/17 and sent a second time on 10/5/17 via email from the Director of Operations when requested by the surveyor who conducted the investigation. In the future, information at the time of the survey or investigation will be provided in a timely manner. This has been reviewed with the RN/DNS.

Complete 9/22/17 + 10/5/17

R178 SS=E

1) SVE has changed the policy for overnight staff. One caregiver will work with a resident that has any behavior concerns so the others can continue to do the safety checks or

other job duties. The staff in question were trained in dementia however will be re-trained with an emphasis on behaviors on October 15 and/or 17, 2017. complete 10/15+17/2017

2) In speaking with Captain Rick Gary at the Essex Police Department he stated he had no concerns with our community. It is a community on Carmichael St. where they are "inodiated with calls and have to respond because they get no response when they call back."

3) The acting ED had a discussion with the DON regarding the importance of addressing resident behaviors immediately. The DON will address this with all nurses and med techs in a meeting on October 20, 2017. Since this incident the resident was hospitalized and medications were changed. The resident's care plan was updated since her return from the hospital. The ED will audit the charts weekly to insure the care plans and assessments are completed in a timely manner. Any issues identified will be addressed with the staff person involved immediately. Audits will be reviewed weekly at the Quality Assurance meeting scheduled for Thursdays at 1:00pm. Complete 10/20/17

4) The Food Service Director and dietary team will ensure that all foods will be cut appropriately for residents coming straight from the kitchen.

5) There is a new procedure in place for the dining room. One staff member will remain in the dining room at all times while the others provide the food or attend to other needs of the residents. This was in-serviced on 9/27/17. complete 9/27/17

6) Since the complaint investigation a document was found dated 8/28/17 that indicates who has had dementia training. The three staff members on the night of the incident with resident #1 were listed on this document. However, all three will attend a re-training on October 15, 2017 with an emphasis on behaviors. Complete 10/15/17

7) Two agencies were contracted to assist the community in their staffing needs as of September 25, 2017. Agency will stay in place until the community has hired all staff necessary to meet the needs of the residents of a special care unit. The supervisor will review staffing levels daily and adjust accordingly to ensure appropriate staffing to accommodate the needs of the residents in the Community. Results of the daily review will be reported at the Quality Assurance Meeting.

R179 SS=E

1) The community opened in November 2016. All staff upon orientation prior to starting their schedule hired for are required to do the 12-hour training requirements. The

community has conducted in house monthly trainings since opening and will continue to do so going forward.

2) SVE has changed the policy for overnight staff. One caregiver will work with a resident that has any behavior concerns so the others can continue to do the safety checks or other job duties. The staff in question were trained in dementia however will be re-trained with an emphasis on behaviors on October 15 and/or 17, 2017. The supervisor will review All behavioral interventions with the care staff as they are added to the care plan. The supervisor will observe staff to ensure that behavioral interventions are implemented as addressed in the care plan. Any issues identified will be addressed with the individual involved for re-training. Retraining methods will include role play, return demonstration and discussion. Results of intervention observation will be reviewed at the Quality Assurance Meeting. Complete 10/15+17/2017

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5) The RN/DNS is responsible for the care plans of the residents. The Memory Care Director takes the information of the care plans and inputs it into an assignment sheet the care providers use to care for the residents on a daily basis. The RN/DNS is involved in all care aspects of the residents as well as clinical. If there are any concerns or issues they are discussed with the RN/DNS for direction or updates in the care plans. The Memory Care Director trains all staff in dementia using her previous training, videos and several documents specific to dementia.

- All the above has been added to the QA checklist that the DOO will be reviewing weekly until the Executive Director is replaced. DOO will do monthly QA visits to ensure the community is in compliance with the POC.

Respectfully Submitted,

A. Pelletier

Angela Pelletier – Acting Executive Director – SVE/Director of Operations – WSL

10/24/17 - resent with updates